		FOR OHF USE					

LL1

2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0033761

Facility Name: Rose-Angela Hall

Address: 4200 N. Austin Avenue (Number) Chicago (City) 60634 (Zip Code)

County:

Telephone Number: 773-545-8300 **Fax #** 773-545-2984

IDPA ID Number: 36-2171748001

Date of Initial License for Current Owners: 08/19/88

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 501c3			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Beverly Sorensen **Telephone Number:** 773-545-8300X1311

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/04 to 06/30/05 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) (Date) 09/19/05
(Type or Print Name) Sr. Rita Butler
(Title) Director

Paid Preparer

(Signed) (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Rose-Angela Hall # 0033761 Report Period Beginning: 07/01/04 Ending: 06/30/05

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	80	Intermediate/DD	80	29,200	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	80	TOTALS	80	29,200	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	26,536			26,536	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	26,536			26,536	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.88%

D. How many bed-hold days during this year were paid by the Department? 2,554 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
none

F. Does the facility maintain a daily midnight census? yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 9/13/88

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [ ]

Tax Year: 06/30/05 Fiscal Year: 06/30/05

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Rose-Angela Hall # 0033761 **Report Period Beginning:** 07/01/04 **Ending:** 06/30/05

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	158,146	12,572	23,024	193,742		193,742		193,742			1
2	Food Purchase		104,016		104,016		104,016		104,016			2
3	Housekeeping	53,830	10,815		64,645		64,645		64,645			3
4	Laundry	15,636	2,513		18,149		18,149		18,149			4
5	Heat and Other Utilities			119,549	119,549		119,549		119,549			5
6	Maintenance	94,541	91,929	91,135	277,605		277,605		277,605			6
7	Other (specify):*											7
8	**TOTAL General Services**	322,153	221,845	233,708	777,706		777,706		777,706			8
	B. Health Care and Programs											
9	Medical Director	29,245			29,245		29,245		29,245			9
10	Nursing and Medical Records	1,538,722	25,806	24,132	1,588,660		1,588,660		1,588,660			10
10a	Therapy	23,581		35,470	59,051		59,051		59,051			10a
11	Activities	58,669			58,669		58,669		58,669			11
12	Social Services	17,105			17,105		17,105		17,105			12
13	CNA Training	12,949	90		13,039		13,039		13,039			13
14	Program Transportation		13,405		13,405		13,405		13,405			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,680,271	39,301	59,602	1,779,174		1,779,174		1,779,174			16
	C. General Administration											
17	Administrative	101,477			101,477		101,477		101,477			17
18	Directors Fees											18
19	Professional Services			37,026	37,026		37,026		37,026			19
20	Dues, Fees, Subscriptions & Promotions			3,811	3,811		3,811		3,811			20
21	Clerical & General Office Expenses	158,961	52,573	12,946	224,480		224,480		224,480			21
22	Employee Benefits & Payroll Taxes			328,137	328,137		328,137		328,137			22
23	Inservice Training & Education			350	350		350		350			23
24	Travel and Seminar			774	774		774		774			24
25	Other Admin. Staff Transportation		1,828		1,828		1,828		1,828			25
26	Insurance-Prop.Liab.Malpractice			60,025	60,025		60,025		60,025			26
27	Other (specify):*											27
28	**TOTAL General Administration**	260,438	54,401	443,069	757,908		757,908		757,908			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,262,862	315,547	736,379	3,314,788		3,314,788		3,314,788			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Rose-Angela Hall #0033761 **Report Period Beginning:** 07/01/04 **Ending:** 06/30/05

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			255,287	255,287		255,287		255,287			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			255,287	255,287		255,287		255,287			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			215,808	215,808		215,808		215,808			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			215,808	215,808		215,808		215,808			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,262,862	315,547	1,207,474	3,785,883		3,785,883		3,785,883			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Rose-Angela Hall # 0033761 **Report Period Beginning:** 07/01/04 **Ending:** 06/30/05

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Rose-Angela Hall

ID# **0033761**

Report Period Beginning: **07/01/04**

Ending: **06/30/05**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	0		49

STATE OF ILLINOIS **Summary A**

Facility Name & ID Number Rose-Angela Hall **#** 0033761 **Report Period Beginning:** 07/01/04 **Ending:** 06/30/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	0	0	0	0	0	0	0	0	0	0	0	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	0	0	0	0	0	0	0	0	0	0	0	0	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Rose-Angela Hall** **# 0033761** **Report Period Beginning:** **07/01/04** **Ending:** **06/30/05**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	0	0	0	0	0	0	0	0	0	0	0	0	45

Facility Name & ID Number Rose-Angela Hall # 0033761 Report Period Beginning: 07/01/04 Ending: 06/30/05

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Daughters of St. Mary of Providence	100			St. Mary of Providence	Chicago, IL	Operating Corp.

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		Rent Facility/	$			$	$	1
2	V		Bldg, Grounds	66,000	Daughters of St. Mary of Providence	100.00%	66,000		2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 66,000			$ 66,000	$ *	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Rose-Angela Hall # 0033761 Report Period Beginning: 07/01/04 Ending: 06/30/05

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

*** If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.**

**** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION**

Facility Name & ID Number Rose-Angela Hall # 0033761 Report Period Beginning: 07/01/04 Ending: 06/30/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Daughters of St. Mary of Providence
Street Address: 4200 N. Austin Avenue
City / State / Zip Code: Chicago, IL 60634
Phone Number: (773-545-8300
Fax Number: (773-545-2984

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Rose-Angela Hall **#** 0033761 **Report Period Beginning:** 07/01/04 **Ending:** 06/30/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	**TOTAL Facility Related**						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	**TOTAL Non-Facility Related**						$	$			$	14
15	**TOTALS (line 9+line14)**						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Rose-Angela Hall **#** 0033761 **Report Period Beginning:** 07/01/04 **Ending:** 06/30/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2004 report.	***Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	2000	8
	2001	9
	2002	10
	2003	11
	2004	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Rose-Angela Hall COUNTY _____

FACILITY IDPH LICENSE NUMBER 0033761

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE ( ) _____ FAX #: ( ) _____

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number Rose-Angela Hall # 0033761 Report Period Beginning: 07/01/04 Ending: 06/30/05

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 51,510 B. General Construction Type: Exterior Brick Frame _____ Number of Stories _____

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Providence Center - Community Living Facility 13647 Sq. Ft. 16 beds
Rose Angela Hall - Day Training Facility 34671 sq. Ft. 115 day units
Providence Center - Adult Work Activity(now part of DT) 6653 sq. ft. 115 day units

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Residential	66,437	1925	$ 50,975	1
2	Improvements		Various	24,500	2
3	TOTALS	66,437		$ 75,475	3

Facility Name & ID Number Rose-Angela Hall # 0033761 Report Period Beginning: 07/01/04 Ending: 06/30/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	80		1979	1980	$ 2,031,195	$ 17,314	30	$ 17,314	$	$ 1,850,614	4
5			1938	1938	73,366		60			73,366	5
6			1956	1956	259,122		25			259,122	6
7			1928	1928	104,867		45			104,867	7
8			1953	1953	71,484		45			71,484	8
	Improvement Type**										
9	Remodling Painting Drywall			1980	85,251		20			85,251	9
10	Repairs			1980	24,301	243	20	243		23,805	10
11	Roof/tuckpointing			1988	8,466	423	20	423		7,155	11
12	Repairs, Painting Decorating			1955	41,231		10			41,231	12
13	Decorating			1990	3,836	170	10	170		3,789	13
14	Asphalt Paving Lot			1990	16,650		15			16,650	14
15	Garage Disposal			1990	24,862	995	25	995		15,917	15
16	Remodling			1991	45,685	2,284	20	2,284		31,287	16
17	New boiler-Kitchen Bldg.			1998	12,320	821	15	821		6,568	17
18	New boiler-Adm. Bldg.			1998	5,320	355	15	355		2,840	18
19	Install Handicap ramp/remodel front entrance			2001	140,185	7,010	20	7,010		31,545	19
20	Remove & install new fence aound perimeter&electronic gate			2001	106,000	5,300	20	5,300		23,850	20
21	Addl re electronic gates & fence			2002	19,421	971	20	971		3,884	21
22	New rooftop HVAC units to replace existing			2002	248,000	16,533	15	16,533		56,865	22
23	Addl re ramp & fence ICF			2003	103,055	5,153	15	5,153		12,882	23
24	Sidewalks Underground SnowMelt			2004	41,354	2,067	20	2,067		3,101	24
25	Parking lot stone & asphalt			2004	35,732	2,382	15	2,382		3,573	25
26	Carpentry, Shelving,Gate			1988	44,779		15			44,779	26
27	Outdoor rec. area			1989	12,400	410	15	410		12,400	27
28	G. Hall windows AC			1991	24,239	1,212	20	1,212		17,299	28
29	Roofing			1991	10,852		20			10,852	29
30	Remodling Nurses Station, Adm Bldg.			1991	156,249	7,916	20	7,916		117,473	30
31	Walk in Cooler remodling			1991	44,095	2,205	20	2,205		30,221	31
32	Remodling kitchen			1991	31,445	1,572	10	1,572		22,794	32
33	Roofing			1992	12,170	(552)	15	(552)		12,170	33
34	Remodling Nurses Station, Adm Bldg.			1993	30,813	2,054	15	2,054		25,675	34
35	Painting decorative tile			1992	14,977		10			14,977	35
36	Alarm system			1994	10,837	394	10	394		8,973	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Rose-Angela Hall # 0033761 Report Period Beginning: 07/01/04 Ending: 06/30/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Emergency lights, snow melt cables, roofing	1995	$ 65,535	$ (1,187)	10	$ (1,187)	$	$ 65,535	37
38	Handicap Bath, Whirlpool	1996	19,365	1,291	15	1,291		12,103	38
39	Painting, Patching, Decorating	1996	37,184	(2,259)	5	(2,259)		37,184	39
40	New Boiler #1-4	1996	32,273	1,614	20	1,614		15,199	40
41	Install Bath	1996	4,208	281	15	281		2,669	41
42	Repair Glass, roofing	1996	2,996		15			2,996	42
43	Tuckpointing, rof repair	1997	6,428	642	10	642		5,457	43
44	Electrical re a/c	1997	2,460	164	15	164		1,476	44
45	Window replacment a/c installation	1997	23,947	1,198	20	1,198		10,183	45
46	Painting, wall covering	1997	1,462		5			1,462	46
47	Architectural re windows, remodling	1998	930	92	10	92		690	47
48	Elevator door	1998	1,200	80	15	80		600	48
49	New orrf Sdm. Bldg	1998	13,968	698	20	698		5,235	49
50	Painting decorating Adm. Bldg	1998	950	(95)	5	(95)		950	50
51	Guanella Hall boiler	1998	14,758	738	20	738		5,535	51
52	New doors, stlops, exits	1998	15,989	1,066	15	1,066		7,995	52
53	Painting, decorating	1998	25,548	(2,553)	5	(2,553)		25,548	53
54	Handrails	1998	6,132	408	15	408		3,060	54
55	New boiler, ht coils d#1	1998	53,531	2,676	20	2,676		20,126	55
56	Painting, decorating Dorms	1999	18,294	(1,830)	5	(1,830)		18,294	56
57	Handicap handrails installed	1999	14,174	945	15	945		6,142	57
58	Install walkin kitchen freezer	1999	17,409	1,161	15	1,161		7,547	58
59	Reconfigure office, and handicap ramp & washroom	1999	54,060	2,703	20	2,703		17,570	59
60	Replace broken sewer & sidewalk	1999	17,168	859	20	859		5,583	60
61	New wallcovering and decorating g. Hall	1999	23,831	2,383	10	2,383		15,489	61
62	Installation of fire pump	1999	8,300	415	20	415		2,698	62
63	Pip in new heads re fire system	1999	2,060	137	15	137		891	63
64	Chapel roof repair & piping	1999	2,939	294	10	294		1,893	64
65	Carpeting Chapel	2000	1,511	302	5	302		1,253	65
66	Painting, wall covering re hallways	2000	1,742	174	10	174		957	66
67	New heaters hallways	2000	656	44	15	44		264	67
68	Remodel Kotachen ramp	2000	35,464	1,773	20	1,773		10,622	68
69	Pavement repairs & Replace	2000	10,527	526	20	526		2,891	69
70	TOTAL (lines 4 thru 69)		$ 4,431,558	$ 91,972		$ 91,972	$	$ 3,363,356	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Rose-Angela Hall # 0033761 Report Period Beginning: 07/01/04 Ending: 06/30/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 4,431,558	$ 91,972		$ 91,972	$	$ 3,363,356	1
2	Install water supply valves	2000	21,820	1,091	20	1,091		6,000	2
3	Windows replaced in dorms	2000	85,550	4,278	20	4,278		23,529	3
4	Roof repair dorms	2000	13,520	1,352	10	1,352		7,436	4
5	Replace kitchen windows	2000	10,553	528	20	528		3,168	5
6	Brickwork, concrete re damaged walls	2000	8,885	444	20	444		2,242	6
7	New freezer to cooler	2000	63,982	3,199	20	3,199		17,610	7
8	Electric HVAC re freezer	2000	13,022	651	20	651		3,581	8
9	New water line piping	2000	11,006	550	20	550		3,025	9
10	Electric outlets emergency lights	2000	6,858	457	15	457		2,513	10
11	Asphalt paving lit	2001	5,141	1,028	5	1,028		4,384	11
12	Fire alarm system	2001	6,938	694	10	694		3,123	12
13	G Hall decorating happways	2001	5,540	1,108	5	1,108		4,986	13
14	Remove asbestos tile/replace	2001	5,192	519	10	519		2,337	14
15	Firewall door framing	2001	22,631	1,508	15	1,508		6,786	15
16	New hot water tranks repiping	2001	24,801	1,654	15	1,654		7,476	16
17	Shower door, replace drain	2001	11,732	782	15	782		3,520	17
18	Outdoor pavilion, gazebos	2001	41,095	2,740	15	2,740		12,329	18
19	Balcony roof repair	2002	5,803	1,160	5	1,160		3,787	19
20	Fire alarm system	2002	4,496	450	10	450		1,575	20
21	Plumbing work	2002	42,173	4,217	10	4,217		14,759	21
22	Sidewalk replacement	2002	23,012	1,534	15	1,534		5,369	22
23	Electric re HVAC	2002	15,700	1,046	15	1,046		3,661	23
24	Tuckpointing	2002	11,585	1,158	10	1,158		4,053	24
25	Doors re Chapel	2003	1,642	164	10	164		410	25
26	Plumbing-Water tanks sm basin	2003	16,551	1,655	10	1,655		4,138	26
27	Roof curbs	2003	12,430	829	10	829		2,072	27
28	Elec. Wiring&smoke detectors	2003	5,327	532	15	532		1,335	28
29	Insolate pipes, door	2003	4,378	438	10	438		1,095	29
30	Windows, tuckpointing, Nepco	2003	25,922	2,592	10	2,592		6,480	30
31	Gas Generator	2004	189,933	12,662	10	12,662		18,993	31
32	Roof tiles, decorating	2004	21,956	4,391	5	4,391		6,588	32
33	New laundry area	2004	17,227	1,148	15	1,148		1,722	33
34	TOTAL (lines 1 thru 33)		$ 5,187,959	$ 148,531		$ 148,531	$	$ 3,553,438	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Rose-Angela Hall # 0033761 Report Period Beginning: 07/01/04 Ending: 06/30/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 5,187,959	$ 148,531		$ 148,531	$	$ 3,553,438	1
2	Corridor rails, stairs	2004	26,110	1,741	15	1,741		2,734	2
3	Base parking lot, undergrnd snow melt	2004	52,967	5,296	10	5,296		7,749	3
4	New fire alarm system	2004	68,500	4,567	15	4,567		6,850	4
5	A/C kitchen	2004	9,890	989	10	989		1,484	5
6	Gym building elevator	2004	84,205	4,210	20	4,210		8,420	6
7	Handicap ramp re gym	2004	34,730	1,736	20	1,736		3,472	7
8	Gym windows	2004	8,245	550	15	550		1,100	8
9	Gym foofing	2004	17,997	3,600	5	3,600		7,200	9
10	Plumbing, washroom remodel	2004	6,468	647	10	647		1,294	10
11	Exterior masonry, joints	2004	32,686	2,180	15	2,180		3,244	11
12	Gas Generator, balance	2005	26,180	873	15	873		873	12
13	Complete roof replacement	2005	380,077	9,502	20	9,502		9,502	13
14	Installation Attic exhaust	2005	99,968	2,499	20	2,499		2,499	14
15	Complete new fire alarm system	2005	130,900	3,272	20	3,272		3,272	15
16	Sewer & gas lines	2005	47,795	1,995	20	1,995		1,995	16
17	Paving lot	2005	31,920	1,064	15	1,064		1,064	17
18	Wallcover, tiles, painting	2005	69,115	3,456	10	3,456		3,456	18
19	Electrical repairs, security	2005	30,411	1,520	10	1,520		1,520	19
20	Laundry/Kitchen repairs	2005	30,103	649	15	649		649	20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,376,226	$ 198,877		$ 198,877	$	$ 3,621,815	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Rose-Angela Hall # 0033761 Report Period Beginning: 07/01/04 Ending: 06/30/05

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 573,317	$ 34,319	$ 34,319	$		$ 485,611	71
72	Current Year Purchases	87,765	16,759	16,759			16,759	72
73	Fully Depreciated Assets	138,169					138,169	73
74								74
75	TOTALS	$ 799,251	$ 51,078	$ 51,078	$		$ 640,539	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Care	Windstar 2004	2004	$ 21,328	$ 5,332	$ 5,332	$	4	$ 7,998	76
77										77
78										78
79										79
80	TOTALS			$ 21,328	$ 5,332	$ 5,332	$		$ 7,998	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 7,272,280	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 255,287	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 255,287	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,270,352	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Rose-Angela Hall # 0033761 Report Period Beginning: 07/01/04 Ending: 06/30/05

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. _____
This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

10. Effective dates of current rental agreement:
Beginning _____
Ending _____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ _____ Description: _____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Rose-Angela Hall # 0033761 Report Period Beginning: 07/01/04 Ending: 06/30/05

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM	X
IN OTHER FACILITY	
COMMUNITY COLLEGE	
HOURS PER CNA	40

3. CLINICAL PORTION:

IN-HOUSE PROGRAM	X
IN OTHER FACILITY	
HOURS PER CNA	80

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies		90		90
3	Classroom Wages (a)		4,312		4,312
4	Clinical Wages (b)		8,637		8,637
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$ 13,039	$	$ 13,039
10	SUM OF line 9, col. 1 and 2 (e)	$ 13,039			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	12
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	12

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Rose-Angela Hall **#** 0033761 **Report Period Beginning:** 07/01/04 **Ending:** 06/30/05

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 06/30/05 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$ 731,459	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	484,609	718,106	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance		39,163	6
7	Other Prepaid Expenses		9,422	7
8	Accounts Receivable (owners or related parties)	(1,590,106)		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ (1,105,497)	$ 1,498,150	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	2,283,477	5,101,506	15
16	Equipment, at Historical Cost	820,579	1,374,697	16
17	Accumulated Depreciation (book methods)	(1,275,354)	(3,106,908)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,828,702	$ 3,369,295	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 723,205	$ 4,867,445	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 20,940	$ 100,177	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	79,040	179,610	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,352	5,880	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 102,332	$ 285,667	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 102,332	$ 285,667	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 620,873	$ 4,581,778	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 723,205	$ 4,867,445	48

***(See instructions.)**

Facility Name & ID Number Rose-Angela Hall **#** 0033761 **Report Period Beginning:** 07/01/04 **Ending:** 06/30/05

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 786,281	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 786,281	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(165,408)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (165,408)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 620,873	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Rose-Angela Hall # 0033761 Report Period Beginning: 07/01/04 Ending: 06/30/05

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,599,162	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,599,162	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	12,949	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 12,949	23
	D. Non-Operating Revenue		
24	Contributions	8,364	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 8,364	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,620,475	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	777,706	31
32	Health Care	1,779,174	32
33	General Administration	757,908	33
	B. Capital Expense		
34	Ownership	255,287	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	215,808	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,785,883	40
41	**Income before Income Taxes (line 30 minus line 40)****	(165,408)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (165,408)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? n/a If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Rose-Angela Hall # 0033761 Report Period Beginning: 07/01/04 Ending: 06/30/05

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,720	1,820	$ 43,678	$ 24.00	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,304	4,579	112,501	24.57	3
4	Licensed Practical Nurses	10,220	10,872	233,842	21.51	4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,702	2,874	58,264	20.27	9
10	Activity Assistants	71	71	405	5.70	10
11	Social Service Workers	356	356	17,105	48.05	11
12	Dietician					12
13	Food Service Supervisor	1,960	2,080	45,474	21.86	13
14	Head Cook	292	292	4,762	16.31	14
15	Cook Helpers/Assistants	10,622	11,301	107,910	9.55	15
16	Dishwashers					16
17	Maintenance Workers	4,563	4,854	94,541	19.48	17
18	Housekeepers	5,822	6,194	53,830	8.69	18
19	Laundry	1,941	2,065	15,636	7.57	19
20	Administrator	2,444	2,600	71,370	27.45	20
21	Assistant Administrator	1,388	1,477	30,107	20.38	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,455	11,122	158,961	14.29	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director	250	250	29,245	116.98	27
28	Qualified MR Prof. (QMRP)	12,300	13,084	238,335	18.22	28
29	Resident Services Coordinator	10,390	11,046	179,786	16.28	29
30	Habilitation Aides (DD Homes)	75,800	80,594	740,505	9.19	30
31	Medical Records	1,700	1,806	26,605	14.73	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	159,300	169,337	$ 2,262,862 *	$ 13.36	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	130	$ 4,620	Lin 1 C3	35
36	Medical Director				36
37	Medical Records Consultant	37	1,488	Lin 10 C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	575	31,375	Lin 10aC3	40
41	Occupational Therapy Consultant	76	4,095	Lin 10aC3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Dentist	n/a	3,345	Lin 10C3	46
47	Psychologist-Psychiatrist	88	7,345	Lin 10 C3	47
48	FoodService Professinal Mgmt Fee		18,404	Lin 1 C3	48
49	TOTAL (lines 35 - 48)	906	$ 70,672		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	352	11,954	Lin 10 C3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	352	$ 11,954		53

Facility Name & ID Number Rose-Angela Hall # 0033761 Report Period Beginning: 07/01/04 Ending: 06/30/05

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Sr. Janet Kosman	Administrator		$ 71,370
Darlene Zadnowski	Asst Administrator		30,107
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 101,477

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
Deloitte & Touche LLP	Audit	$ 37,026
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 37,026

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 36,165
Unemployment Compensation Insurance	2,407
FICA Taxes	140,514
Employee Health Insurance	92,155
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension	56,896
TOTAL (agree to Schedule V, line 22, col.8)	$ 328,137

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	3,243
Health Care Worker Background Check	
(Indicate # of checks performed 23)	368
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 3,811

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Arch - QMRP leadershipDD workforce	390
INR stress ,pain	158
Skill Finacial stmt	226
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 774

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Rose-Angela Hall # 0033761 Report Period Beginning: 07/01/04 Ending: 06/30/05

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Rose-Angela Hall **#** 0033761 **Report Period Beginning:** 07/01/04 **Ending:** 06/30/05

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **NO**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **5**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **2,645** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **215,808**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **15%**
d. Have vehicle usage logs been maintained? **YES**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **0**

(17) Has an audit been performed by an independent certified public accounting firm?
Firm Name: **Deloitte & Touche LLP** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **n/a**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report?
Attach invoices and a summary of services for all architect and appraisal fees.

FACILITY NAME & ID NUMBER - Rose Angela Hall #0033761
Report Period: July 1, 2004 - June 30, 2005

SCHEDULE VII -A- PAGE 24

List of Board Members during period July 1, 2004 - June 30, 2005-

NAME	OFFICE
Sr. Patricia McCafferty	President
Sr. Rita Butler (1)	Vice-President
Sr. Antoinette Palmisano	Treasurer
Sr. Janet Kosman	Secretary
Sr. Noreen Franzina	Director

(1) Sr. Rita Butler approves invoices for payment and oversees maintenance of buildings.

The facility pays rent to the religious order, The Daughters of St. Mary of Providence for use of the buildings and grounds.

SCHEDULE VIII Allocation of Indirect Costs SEE ATTACHED WORKSHEETS